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STATE OF WISCONSIN BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY:

PROCEEDINGS AGAINST

FINAL DECISION AND ORDER

ANDREW J. DINKINS, LPN : LS0508313NUR

RESPONDENT.

02 NUR 063

The parties to this action for the purposes of Wis. Stat. § 227.53 are:

Andrew J. Dinkins, LPN 3403 North 20th Street Milwaukee, WI 53206

Division of Enforcement
Department of Regulation and Licensing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708-8935

Wisconsin Board of Nursing Department of Regulation & Licensing 1400 East Washington Avenue P.O. Box 8935 Madison, WI 53708-8935

PROCEDURAL HISTORY

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Wisconsin Board of Nursing. The Board has reviewed the attached Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

- 1. Andrew J. Dinkins, LPN, Respondent herein, 3403 North 20th Street, Milwaukee, Wisconsin 53206, was born on 11/10/69 and is licensed to practice as a practical nurse in the state of Wisconsin, license #33800, said license having been granted on 9/9/96.
- 2. On 2/28/02, Respondent was employed as a licensed practical nurse at the Milwaukee Catholic Home in Milwaukee, Wisconsin and was scheduled to work on the second shift on the Orthopedic/Rehabilitation Unit at the facility. Respondent's shift was scheduled to begin on 2/28/02 at 1430 and end at 2300.
- 3. On 2/28/02, the Orthopedic/Rehabilitation Unit had a population of 31 patients, 21 of which were long-term care patients and 10 of which were Medicare patients, and was scheduled to be staffed by 2 nurses who were to be assisted by certified nursing assistants.
 - 4. Respondent logged in for the second shift at the facility at 1429 on 2/28/02.
- 5. At approximately 1430 on 2/28/02, the two nurses who had staffed the Orthopedic/Rehabilitation Unit on the first shift presented their reports to Respondent and the other licensed practical nurse assigned to staff this unit for the second shift. At approximately 1445, while the reports were in progress, the Director of Nursing for the facility contacted the unit to determine which nurse had been assigned to care for the 10 Medicare patients. Respondent spoke with the Director of Nursing by telephone and was advised by the Director of Nursing that he had been assigned to care for the 10 Medicare patients.
- 6. Upon being advised by the Director of Nursing that he had been assigned to care for the 10 Medicare patients on the unit, Respondent responded to the Director of Nursing that this assignment was not fair, that he had been assigned to the 21 long-term care patients on the previous evening and that he did not want to change the assignment from the previous evening. The Director of Nursing advised him that the assignment did not present a question of fairness but rather what was best for the patients. The conversation between the Director of Nursing and the Respondent terminated leaving the Director of Nursing with the understanding that the Respondent would be caring for the 10 Medicare patients throughout the second shift.
- 7. At approximately 1450, the Respondent left the facility without notice to the Director of Nursing or to any other person in authority. The Respondent did not make arrangements with any other nurse prior to his departure to provide coverage for the patients assigned to him. The Respondent did not return to the facility on 2/28/02 or at any time thereafter.
- 8. The Director of Nursing, upon ascertaining that the Respondent had left the facility, made arrangements for nursing coverage for the patients assigned to the Respondent.
- 9. The events described in paragraphs 2 through 8 occurred at the change of shift and the nurses present from the first shift continued to provide nursing care for the patients at the change of shift. No patient was denied nursing care as a result of the incident. The incident did not result in abuse or neglect of any patient.

CONCLUSIONS OF LAW

- 1. The Wisconsin Board of Nursing has jurisdiction to act in this matter, pursuant to Wis. Stat. § 441.07, and is authorized to enter into the attached Stipulation and Final Decision and Order, pursuant to Wis. Stat. § 227.44(5).
- 2. The conduct described in the Findings of Fact constitutes a violation of Wis. Admin. Code §§ N7.03(1)(a), N6.05 and N6.04(1)(b) in that Respondent failed to provide nursing care to the patients' assigned to him on 2/28/02.
- 3. The Wisconsin Board of Nursing has the authority pursuant to Wis. Stat. § 440.22 to assess the costs of this proceeding against the Respondent.
- 4. This Final Decision and Order shall not be construed as a Board of Nursing finding of caregiver misconduct, abuse or neglect of a client, or misappropriation of the property of a client within the meaning of Wis. Stat. §§ 48.685 and 50.065.

NOW, THEREFORE, IT IS HEREBY ORDERED that:

- 1. Andrew J. Dinkins, LPN, is hereby REPRIMANDED.
- 2. The license of Andrew J. Dinkins to practice as a licensed practical nurse in the state of Wisconsin is hereby limited as follows:
 - a. Andrew J. Dinkins will within 6 months of the date of this Final Decision and Order take and satisfactorily complete a minimum of 8 credit hours of continuing education in professional ethics. The continuing education courses taken in satisfaction of this requirement will be pre-approved by the Board of Nursing or its designee. Respondent will attend each course taken in satisfaction of this requirement in its entirety.
 - b. Andrew J. Dinkins will within 60 days of completion of the required continuing education courses in professional ethics provide evidence satisfactory to the Board of Nursing that he has attended each of the approved courses in its entirety. This evidence will include:
 - i. Certification of attendance from the sponsoring organization; and
 - ii. Affidavit given under oath by Andrew J. Dinkins verifying that he has attended each of the approved courses in its entirety.
 - c. Andrew J. Dinkins will pay all costs of attending the approved courses and of verifying attendance at the courses.
 - d. All requests for approval of courses, certifications of attendance, affidavits and other documents required to be filed with the Board of Nursing will be mailed, faxed or delivered to:

Department Monitor
Division of Enforcement

Department of Regulation and Licensing
P.O. Box 8935

Madison, WI 53708-8935

Telephone (608) 267-3817

Fax (608) 266-2264

e. The limited license will terminate and Andrew J. Dinkins' license will be restored to full and unrestricted active status when all of the terms of this Final Decision and Order have been complied with

IT IS FURTHER ORDERED that:

3. Respondent will, within 120 days from the date of this Final Decision and Order, pay costs of this proceeding in the amount of \$1,800.00. Payment shall be made payable to the Wisconsin Department of Regulation and Licensing, and mailed to:

Department Monitor
Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison, WI 53708-8935
Telephone (608) 267-3817

- 4. Violation of any of the terms of this Final Decision and Order may be construed as conduct imperiling public health, safety and welfare and may result in a summary suspension of Andrew J. Dinkins' license. The Board of Nursing in its discretion may in the alternative impose additional conditions and limitations or other additional discipline for a violation of any of the terms of this Final Decision and Order. In the event Andrew J. Dinkins fails to timely submit any payment of the costs as ordered or fails to comply with the ordered education his license #33800 SHALL BE SUSPENDED, without further notice or hearing, until Andrew J. Dinkins has complied with the terms of this Final Decision and Order.
 - 5. This Final Decision and Order is effective on the date of its signing.

Wisconsin Board of Nursing

By: Jacqueline Johnsrud, RN, MS
A Member of the Board

11/10/05

Date